Iowa Department of Human Services
OBLIGOR INSURANCE QUESTIONNAIRE

Obligor:

Date Prepared:
Case Number: #

Obligee/Caretaker:

Dependents:

Dear Parent:

The Department of Human Services, Child Support Recovery Unit (CSRU), is responsible for gathering information on health insurance coverage of the dependents listed above. We need to ensure that the health insurance information in our records is correct and ensure your children receive all the health benefits due under your medical insurance plan. Please complete this form and return it, within 10 days.

Do you have health insurance for the dependents? _____ Yes _____ No
If no, is health insurance coverage for the dependents available through your employer? _____ Yes _____ No Date insurance became available: _____
Monthly cost of the dependent health insurance premium: $ _____

Employer name: _____

Employer address: _____

Location of work site: _____

If you currently provide health insurance for your dependents, please complete the following. There is room to list information for two insurance companies. If there are additional carriers, please provide an attachment.

Health Insurance Benefit Section

	INSURER # 1	INSURER # 2
Name of Insurer:	_____	_____
Address:	_____	_____
	_____	_____
Claims filed with:	_____	_____
Address:	_____	_____
	_____	_____

Coverage Information:

Dependent Name:	INSURER # 1 Policy Numbers:	INSURER # 1 Effective Date:	INSURER # 2 Policy Numbers:	INSURER # 2 Effective Date:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Dependent Health Insurance Premium/Month $ _____ Date Available: _____

Types of Coverage Insurer #1	Types of Coverage Insurer #2
____ Ambulance	____ Ambulance
____ Hospital	____ Hospital
____ Physician	____ Physician
____ Dental	____ Dental
____ Lab & X-Ray	____ Lab & X-Ray
____ Spec Disease - Cancer	____ Spec Disease - Cancer
____ Drugs	____ Drugs
____ Medical Equipment	____ Medical Equipment
____ Spec Disease - Heart	____ Spec Disease - Heart
____ Home Health Agency	____ Home Health Agency
____ Nursing Home - Inter	____ Nursing Home - Inter
____ Vision	____ Vision
____ Hospice	____ Hospice
____ Nursing Home - Skill	____ Nursing Home - Skill

Source Information	Source Information
_____ Accident Policy	_____ Accident Policy
_____ Medicaid Trust	_____ Medicaid Trust
_____ CHAMPUS	_____ CHAMPUS
_____ Medicare - Part A Only	_____ Medicare - Part A Only
_____ CHAMPVA	_____ CHAMPVA
_____ Medicare - Part B Only	_____ Medicare - Part B Only
_____ Indemnity Policy	_____ Indemnity Policy
_____ Medicare - Part A & B	_____ Medicare Part A & B
_____ Major Medical	_____ Major Medical
_____ Veterans Admin	_____ Veterans Admin

If this health insurance coverage is not provided through your employer, what is the name of the group or source providing the coverage?

If your health insurance coverage should lapse or change for any of these dependents, you must inform the CSRU at the address listed below.

Any contact CSRU makes with your current or future employers may include requests for health insurance coverage information.

Please sign here: _____